



# UC IRVINE SCHOOL OF MEDICINE OFFICE OF GRADUATE MEDICAL EDUCATION

## PAST TRAINING ENROLLMENT VERIFICATION (INCOMPLETE TRAINING)

Date: \_\_\_\_\_  
Requested by: \_\_\_\_\_  
Maiden Name (if applicable): \_\_\_\_\_  
Contact Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Training Program(s) Partially Completed at UC Irvine:

\_\_\_\_\_ Dates: \_\_\_\_\_  
\_\_\_\_\_ Dates: \_\_\_\_\_  
\_\_\_\_\_ Dates: \_\_\_\_\_

### **Attestation**

By signing this form, I confirm that I completed partial training at UC Irvine in the program(s) listed above during the dates provided. I am requesting that the UC Irvine Office of Graduate Medical Education complete a past training enrollment verification letter on my behalf. I understand that this document will not be a primary source verification. Inquiries related to past training verification must be submitted to the University of California, Irvine, Office of Graduate Medical Education (GME) for processing. I understand that there is a \$50 processing fee, per verification letter, associated with this request.

Print Legal Name of Authorizing Physician: \_\_\_\_\_

Signature of Authorizing Physician: \_\_\_\_\_

Date: \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

*Your signature must be acknowledged before a Notary Republic.*

### **Notary Section**

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me personally appeared \_\_\_\_\_ to me known to be the person described in and who executed the foregoing instrument and acknowledged the s/he executed the same as his/her free and voluntary act and deed.

Print Name: \_\_\_\_\_

Notary Public, State of \_\_\_\_\_

(Seal)

My commission expires: \_\_\_\_\_

*This document is good for one year from the last date of signature.*